STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

Citation	Condition or Requirement
§1906 of the Act	State Method on Cost Effectiveness of Employer-Based Group Health Plans

§1. Definitions.

The following words and terms, when used in these regulations, shall have the following meanings, unless the context clearly indicates otherwise:

"Case" means all persons who are living in the same household who are eligible for coverage under the group health plan and who are eligible for Medicaid.

"Code" means the Code of Virginia.

"Cost effective" and "cost effectiveness" mean the reduction in Title XIX expenditures, which are likely to be greater than the additional expenditures for premiums and cost-sharing items required under §1906 of the Social Security Act (the Act), with respect to such enrollment.

"DMAS" means the Department of Medical Assistance Services consistent with the Code of Virginia, Chapter 10, Title 32.1, §§32.1-323 et seq.

"DSS" means the Department of Social Services consistent with the Code of Virginia, Chapter 1, Title 63.1, §63.1-1.1 et seq.

"Group health plan" means a plan which meets §5000(b)(1) of the Internal Revenue Code of 1986, and includes continuation coverage pursuant to title XXII of the Public Health Service Act, §4980B of the Internal Revenue Code of 1986, or title VI of the Employee Retirement Income Security Act of 1974. Section 5000(b)(1) of the Internal Revenue Code provides that a group health plan is any plan of, or contributed to by, an employer (including a self-insured plan) to provide health care (directly or otherwise) to the employer's employees, former employees, or the families of such employees or former employees.

"HIPP" means the Health Insurance Premium Payment Program administered by DMAS consistent with §1906 of the Act.

"Premium" means that portion of the cost for the group health plan which is the responsibility of the person carrying the group health plan policy.

"Recipient" means a person who is eligible for Medicaid, as determined by the Department of Social Services.

§2. Program Purpose. The purpose of the HIPP Program shall be:

A. To identify cases in which enrollment of a recipient in an available group health plan is likely to be cost effective;

B. To require that recipients in those cases enroll in the available group health plan as a condition of Medicaid eligibility;

C. To provide for payment of the premiums and other cost-sharing obligations for items and services otherwise covered under the State Plan for Medical Assistance (the Plan); and

D. To treat coverage under such group health plan as a third party liability consistent with §1906 of the Act.

§3. Recipient Eligibility. All persons who are living in the same household who are eligible for coverage under the group health plan and who are eligible for Medicaid shall be eligible for consideration for HIPP, except those identified below. The agency will consider recipients in §3.A. through §3.D. for consideration for HIPP when extraordinary circumstances indicate the group health plan might be cost effective.

A. The recipient is Medicaid eligible due to "spend-down";

B. The recipient is only retroactively eligible for Medicaid;

C. The recipient is in a nursing home or has a deduction from patient pay responsibility to cover the insurance premium; or

D. The recipient is eligible for Medicare Part B, but is not enrolled in Part B.

§4. Condition of Medicaid eligibility. When DMAS determines that a group health plan is likely to be cost effective based on the DMAS established methodology, DSS or DMAS shall require recipients to enroll in that group health plan as a condition of Medicaid eligibility. Non-compliance creates ineligibility for Medicaid until the recipient demonstrates a willingness to comply.

A. Cooperation required. The recipient shall, as a condition of Medicaid eligibility, obtain the required information on the group health plans available to the recipient, shall provide this information to DSS or DMAS, and shall apply for enrollment in the group health plan, as directed by DSS or DMAS unless good cause for failure to cooperate has been established or unless the recipient is unable to enroll on his own behalf. Once the good cause circumstances no longer exist, the recipient shall be required to comply.

B. Non-cooperation of parent or spouse. When a parent or spouse fails to provide DSS or DMAS with the required information necessary to determine availability of a group health plan, fails to enroll in the group health plan that DMAS has determined to be cost effective, as directed by DMAS, or disenrolls from a group health plan that DMAS has determined to be cost effective, eligibility for Medicaid benefits for the recipient child or recipient spouse shall not be affected.

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C. Application required. If the recipient is not already enrolled in a group health plan at the time the cost effectiveness determination is made, the recipient may not be able to enroll in such group health plan until a later date (such as an open enrollment period). The recipient shall provide to DSS or DMAS a completed application for enrollment in the group health plan which DMAS has determined to be cost effective as proof of cooperation within 30 days of receipt of such request from DSS or DMAS. The recipient shall, as a condition of Medicaid eligibility, enroll in the group health plan at the earliest date in which enrollment is possible, unless good cause for failure to cooperate has been established or unless the recipient is unable to enroll on his own behalf.

D. Non-compliance. If a recipient refuses to obtain the required information on group health plans available to the recipient or refuses to provide such information to DSS or DMAS or does not enroll in the group health plan which DMAS has determined to be cost effective, as directed by DMAS, or refuses to provide DSS or DMAS a completed application for enrollment in the group health plan within the deadline given, the recipient shall lose eligibility for Medicaid. Medicaid eligibility shall end after appropriate written notice is given to the recipient as required by 42 CFR §431.211. This ineligibility shall remain effective until the recipient demonstrates willingness to enroll in the group health plan.

E. Disenrollment. If a recipient disenrolls from a group health plan which DMAS has determined to be cost effective, or fails to pay the premium to maintain the group health plan, the recipient shall lose eligibility for Medicaid. Medicaid eligibility shall end after appropriate written notice is given to the recipient as required by 42 CFR §431.211. This ineligibility shall remain effective until the recipient demonstrates willingness to enroll in the group health plan.

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F. Multiple group health plans. When more than one group health plan is available to the recipient, the recipient shall, as a condition of Medicaid eligibility, enroll in one of the group health plans which DMAS has determined to be cost effective, as directed by DSS or DMAS unless good cause for failure to cooperate has been established or unless the recipient is unable to enroll on his own behalf or unless DMAS has determined that none of the available group health plan would be cost effective.

G. All of the requirements pertaining to recipients also apply to parents, spouses, and persons who are acting on behalf of recipients.

§5. Payments. When DMAS determines that a group health plan is likely to be cost effective based on the DMAS established methodology, DMAS shall provide for the payment of premiums and other cost-sharing obligations for items and services otherwise covered under the Plan, except for the nominal cost sharing amounts permitted under §1916.

A. Effective date of premiums. Payment of premiums shall become effective on the first day of the month following the month in which DMAS makes the cost effectiveness determination or the first day of the month in which the group health plan coverage becomes effective, whichever is later. Payments shall be made to either the employer, the insurance company or to the individual who is carrying the group health plan coverage.

B. Termination date of premiums. Payment of premiums shall end:

1. on the last day of the month in which eligibility for Medicaid ends;

2. the last day of the month in which the recipient loses eligibility for coverage in the group health plan, or

3. the last day of the month in which adequate notice has been given (consistent with federal requirements) that DMAS has redetermined that the group health plan is no longer cost effective, whichever comes later.

C. Non-Medicaid eligible family members. Payment of premiums for non-Medicaid eligible family members shall be made when their enrollment in the group health plan is required in order for the recipient to obtain the group health plan coverage. Such payments shall be treated as payments for Medicaid benefits for the recipient. No payments for deductibles, coinsurances and other cost-sharing obligations for non-Medicaid eligible family members shall be made by DMAS.

D. Evidence of Enrollment Required. A person to whom DMAS is paying the group health plan premium shall, as a condition of receiving such payment, provide to DSS or DMAS, upon request, written evidence of the payment of the group health plan premium for the group health plan which DMAS determined to be cost effective.

§6. Guidelines for determining cost effectiveness.

A. Enrollment limitations. DMAS shall take into account that a recipient may only be eligible to enroll in the group health plan at limited times and only if other non-Medicaid eligible family members are also enrolled in the plan simultaneously.

B. Plans provided at no cost. Group health plans for which there is no premium to the person carrying the policy shall be considered to be cost effective.

C. Non-Medicaid eligible family members. When non-Medicaid eligible family members must enroll in a group health plan in order for the recipient to be enrolled, DMAS shall consider only the premiums of non-Medicaid eligible family members in determining the cost effectiveness of the group health plan.

D. Reserved.

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E. DMAS shall make the cost effectiveness determination based on the following methodology:

1. Recipient and group health plan information. DMAS shall obtain demographic information on each recipient in the case, including, but not limited to: federal program designation, age, sex, geographic location. DMAS [or DSS] shall obtain specific information on all group health plans available to the recipients in the case, including, but not limited to: the effective date of coverage, the services covered by the plan, the exclusions to the plan, and the amount of the premium.

2. Average estimated Medicaid expenditures. DMAS shall estimate the average Medicaid expenditures for a 12 month period for each recipient in the case based on the expenditures for persons similar to the recipient in demographic and eligibility characteristics. Expenditures shall be adjusted accordingly for inflation and scheduled provider reimbursement rate increases. Average estimated Medicaid expenditures shall be updated periodically.

3. Medicaid expenditures covered by the group health plan. DMAS shall compute the percentage of expenditures for group health plan services against the expenditures for the same Medicaid services and then adjust the average estimated Medicaid expenditures by this percentage for each recipient in the case. These adjusted expenditures shall be added to obtain a total for the case.

4. Group health plan allowance. DMAS shall multiply an allowance factor by the Medicaid expenditures covered by the group health plan to produce the estimated group health plan allowance. The allowance factor shall be based on a state specific factor, a national factor or a group health plan specific factor.

5. Covered expense amount. DMAS shall multiply an average group health plan payment rate by the group health plan allowance to produce an estimated covered expense amount. The average group health plan payment rate shall be based on a state specific rate, national rate or group health plan specific rate.

6. Administrative cost. DMAS shall total the administrative costs of the HIPP program and estimate an average administrative cost per recipient. DMAS shall add to the administrative cost any pre-enrollment costs required in order for the recipient to enroll in the group health plan.

7. Determination of cost effectiveness. DMAS shall determine that a group health plan is likely to be cost effective if a. is less than b. below:

   a. the difference between the group health plan allowance and the covered expense amount, added to the premium and the administrative cost; and

   b. the Medicaid expenditures covered by the group health plan.

8. If a. is not less than b. above, DMAS shall adjust the amount in b. using past medical utilization data on the recipient, provided by the Medicaid claims system or by the recipient, to account for any higher than average expected Medicaid expenditures. DMAS shall determine that a group health plan is likely to be cost effective if a. is less than b. once this adjustment has been made.

F. Redetermination. DMAS shall redetermine the cost effectiveness of the group health plan periodically, not to exceed every twelve months. DMAS shall also redetermine the cost effectiveness of the group health plan whenever there is a change to the recipient and group health plan information which was used in determining the cost effectiveness of the group health plan. When only part of the household loses Medicaid eligibility, DMAS shall redetermine the cost effectiveness to ascertain whether payment of the group health plan premiums continue to be cost-effective.

G. Multiple group health plans. When a recipient is eligible for more than one group health plan, DMAS shall perform the cost effectiveness determination on the group health plan in which the recipient is enrolled. If the recipient is not enrolled in a group health plan, DMAS shall perform the cost effectiveness determination on each group health plan available to the recipient.

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§7. Third party liability. When recipients are enrolled in group health plans, these plans shall become the first sources of health care benefits, up to the limits of such plans, prior to the availability of Title XIX benefits.

§8. Appeal Rights. Recipients shall be given the opportunity to appeal adverse agency decisions consistent with agency regulations for client appeals (VR 460-04-8.7).

§9. Provider requirements. Providers shall be required to accept the greater of the group health plan's reimbursement rate or the Medicaid rate as payment in full and shall be prohibited from charging the recipient or Medicaid amounts that would result in aggregate payments greater than the Medicaid rate as required by 42 CFR §447.20.

§10. HIPP Program Phase-in across the Commonwealth. The Health Insurance Premium Payment (HIPP) Program will be implemented in phases. The first phase will be implemented in certain pilot areas, full statewide implementation will occur once the pilot phase is completed. DMAS has the Health Care Financing Administration's (HCFA) approval for conducting a pilot phase before full statewide implementation. The pilot phase of the program will be implemented March 1, 1993.